NEW JERSEY ADMINISTRATIVE CODE
TITLE 10. DEPARTMENT OF HUMAN SERVICES
CHAPTER 36. PATIENT SUPERVISION AT STATE PSYCHIATRIC HOSPITALS
(Expires May 21, 2008)

Subchapter 1. Level of Supervision System

10:36-1.1 Introduction and purpose

(a) The Levels of Supervision System is designed to provide a timely, uniform process which affords each patient the structure and intensity of supervision appropriate to his or her condition during the course of hospitalization. The structure provided through the levels system takes the form of an individualized set of clinical interventions, schedule of activities, and conditions under which patients exercise their personal autonomy and liberty. Level determination is based primarily upon the clinical condition of the patient and related behaviors. The Levels of Supervision System is not a treatment modality or a system of earned privileges. It is a mechanism to be utilized in making a clinical determination as to the degree of structure and supervision necessary for each patient to successfully participate in treatment and rehabilitation programs, while maintaining a safe and secure therapeutic milieu for patients and staff alike. Appropriate structure and supervision will also facilitate each patient's successful participation in treatment and rehabilitation programs, which are designed to improve functioning and promote positive social adjustment while hospitalized, and after discharge in the community. The Level of Supervision System is separate from and in addition to the clinical interventions of special precautions (for example, choking, suicide, arson and escape precautions) and special levels

of observations (two- to-one supervision, one-to-one supervision, constant visual observation, periodic visual observation, face checks, and head counts).

(b) The Levels of Supervision System shall be interpreted and implemented in a manner that facilitates the effective treatment of each patient while maintaining the least restrictive setting necessary to accomplish individual goals identified in the treatment plan. Under no circumstances shall this policy be interpreted and implemented in any manner that abridges liberties specified in the "Patients' Bill of Rights" (N.J.S.A. 30:4-24.2 et seq.).

(c) The Treatment Team shall determine the appropriate level for each patient upon admission with review of the assigned level at any time during the course of hospitalization, but, minimally, at the patient's scheduled treatment planning review. Level determinations shall be made in accordance with the parameters set forth herein. Treatment teams shall utilize these parameters to promote increased responsibility, accountability and independence on the part of the patient while decreasing structure and intensity of supervision provided by the staff. Incremental steps taken towards this goal shall be viewed as part of a continuum that progresses through the system toward the goal of discharge with appropriate community supports. The medical record shall contain the documentation that justifies the level determined necessary by the treatment team.

(d) The purpose of the system is:

1. To establish clear guidelines that define parameters of structure and supervision necessary to maintain the safety of patients, hospital staff and the community at large during patient physical movement to and from program sites, related patient treatment services, and leisure time activities.

2. To ensure that all patients receive such considerations in an equitable, consistent and justifiable fashion based on individual clinical considerations.

3. To establish a system that maximizes continuity of care for patients whenever transfer from ward to ward, or hospital section to hospital section becomes appropriate and necessary.

4. To facilitate patient groupings that are optimal for positive social interaction and support progress towards discharge.

10:36-1.2 Definitions

The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Division" means the Division of Mental Health Services, within the Department of Human Services.

"Department" means the Department of Human Services.

"Special status patient" means a patient who:

1. Is charged with, awaiting to be charged with or convicted of one of

the following offenses:

i. Murder;

ii. Manslaughter;

iii. Sexual assault;

iv. Criminal sexual contact;

v. First degree robbery;

vi. Aggravated assault;

vii. Aggravated arson;

viii. Weapons offense; or

ix. Kidnapping.

2. Has been hospitalized because he or she has been adjudicated "Not Guilty by Reason of Insanity" (NGRI) or "Incompetent to Stand Trial" (IST) for one of the enumerated crimes in 1 above under N.J.S.A. 2C:4-1 et seq.

i. If a patient's criminal charges have been dismissed or NGRI or IST status removed, his or her special status designation shall be removed unless he or she meets the standard in 3 below; or

3. Has been determined by the treatment team to be clinically appropriate for consideration by the Special Status Patient review process because of his or her history or other factors indicating a predisposition for serious violent or other high risk behavior.

"Treatment plan" means the plan of care that defines and delineates the comprehensive course of therapeutic and rehabilitative activities proposed for an individual patient, based upon the patient's diagnosis and inventory of strengths and weaknesses. The treatment plan shall establish short-term and long-range goals, the specific treatment modalities to be utilized, and the responsibilities of each member of the treatment team.

"Treatment team" means the organized group of clinical staff who are responsible for the treatment of a specific patient who has been admitted to an adult psychiatric hospital. Members of the team meet to share their expertise with one another; to develop and implement treatment plans; to monitor patient progress; to reassess and make adjustments in treatment plans, as needed; and to plan discharge/aftercare. A patient is expected and shall be permitted to participate in the development of the treatment plan to the extent that his or her clinical condition permits. Family members and significant others are encouraged and shall be permitted to be part of the treatment planning process. Treatment team members shall include, at a minimum, a psychiatrist, a registered nurse, and a social worker. The treatment team shall request the participation of whatever other unit or community liaison staff is necessary for the treatment and responsible discharge of the patient.

"Ward" means that area where a hospitalized patient sleeps, receives services that are medically and therapeutically necessary, and is accounted for in the hospital census.

10:36-1.3 General provisions

(a) The Levels of Supervision System applies to all adult regional State Psychiatric Hospitals.

(b) A description of the Levels of Supervision System shall be posted on all wards and communicated to patients.

(c) With regard to special status patients, the following procedures apply:

1. Prior to implementation, any decrease in supervision or discharge decision shall be approved through hospital administrative review procedures, as delineated in N.J.A.C. 10:36-2.3.
2. An increase to levels 3 or 4 shall be approved through both hospital and Division administrative review.
3. A decision to discharge or transfer a special status patient to a less restrictive setting within the hospital (for example, a cottage) requires approval through both hospital and Division administrative review.
4. In addition to the required reviews in (c)1 through 3 above, any decrease in supervision or discharge decision pertaining to a patient

who is hospitalized because he or she was found "Not Guilty by Reason of Insanity," or "Incompetent to Stand Trial" must be approved by order of the committing court prior to implementation.

(d) A patient may be discharged from the hospital while on any level, when documented as clinically appropriate and, where applicable, when approved by court order.

(e) A patient is not required to go through each level in sequence. The treatment team may increase or decrease the patient's assigned level of supervision as warranted in consideration of a significant change in the patient's clinical condition. The treatment team shall determine the amount of time each patient shall spend at a specific supervision level based upon the patient's clinical needs and treatment goals, and shall adjust the time when clinical progress indicates that an adjustment is appropriate.

(f) Patients who disagree with the treatment team regarding their assigned level of supervision may appeal through hospital grievance procedures or to the Division of Mental Health Services Representative assigned to each institution. The Client Service Representative will involve hospital administration and/or clinical staff as indicated in the resolution of the disagreement.

(g) The Levels of Supervision System shall be monitored by the department in charge of continued quality improvement, or other designee of the Chief Executive Officer at each hospital to ensure that any staffing, programmatic, clinical or other problems are identified and addressed.

10:36-1.4 Procedures

(a) Upon admission, patients shall be placed on Level I of the Levels of Supervision System. Within 72 hours, the treatment team shall assign the level that is most appropriate to the clinical condition and treatment needs of the patient.

(b) Each patient's level shall be evaluated at least as frequently as is called for in the treatment plan review schedule, or more frequently if clinically indicated or requested by the patient. The treatment plan review schedule shall comply, at a minimum, with the standards set by the applicable accrediting body for the hospital. The patient may review his or her treatment plan at any time. A patient's family members, significant others, lawyers, guardians, and custodians are permitted to review a patient's treatment upon their request and prior consent of the patient.

(c) When a sudden change in the patient's behavior or clinical condition constitutes a crisis or emergency to the extent that the current level determination is no longer appropriate, temporary limitations on activities may be

authorized by clinical staff in charge to maintain a safe and secure environment. The rationale for temporary limitations shall be documented in the patient's clinical record and the treatment team shall review the rationale by the next working day and document their findings in the clinical record. The treatment team shall either rescind the limitations when clinically appropriate or continue them for a clinically justified period of time.

(d) All patients ordered "Conditional Extension Pending Placement" by the court shall be accorded the highest level that provides the necessary supervision. A treatment team note shall be entered into the patient's medical record which documents the clinical considerations justifying the supervision level determined necessary by the treatment team.

10:36-1.5 Level I definition, criteria and program structure

(a) Patients who warrant Level I supervision are those who pose a serious risk of harm to themselves, others or property were less supervision provided or who have not yet been evaluated for level of risk or have been recently admitted.

(b) All programming for Level I patients is provided on-ward except for those diagnostic and treatment services that are medically and therapeutically necessary and that cannot be provided on the ward. Determination of these services is the responsibility of the treatment team and shall be documented in the patient's clinical record. All attendance at off-ward services shall be staff

escorted. Brief home visits and off-grounds programming are not permitted at Level I. All patients on Level I shall be provided access to the outdoors and appropriate recreation unless clinically contraindicated.

(c) High risk factors present in an individual that will justify placement of Level I supervision include, but are not limited to:

1. Suicidal ideation or behavior (High Suicide Risk);
2. Homicide risk;
3. Assault risk;
4. Severe impulse control problems;
5. Imminent arson risk;
6. Severe confusion or disorientation, making adjustment to unfamiliar surroundings difficult or impossible;
7. Gross psychotic or mood disorder that causes a risk of imminent harm to self or others;
8. High elopement/walkaway risk as indicated by verbal intent and/or recent history;
9. Past history of violent or homicidal behavior;
10. Physical deterioration; or
11. The presence of acute medical problems.

(d) Staff shall provide for patients at Level I a level of activity that is highly supportive and structured to facilitate the beginning of successful participation

and maximizes the opportunity for successful experiences in treatment for individuals who exhibit Level I criteria. On-ward individual or small group sessions shall be provided to introduce and reinforce processes that elicit information about the patient's needs, problems, and priorities of treatment and introduce expectations regarding the patient's responsibility and ability to influence the course of treatment while hospitalized.

10:36-1.6 Level II definition, criteria and program structure

(a) Patients at Level of Supervision II are those who have begun to form a therapeutic alliance with staff, have shown signs of progress in self-management, exhibit improved mental status or reduction in symptoms, and have improved behavioral controls and increased level of functioning. Patients at Level II still require supervision at most times, though not at the intensity present at Level I.

(b) Programming and services shall be provided both on-ward and off-ward (on or off hospital grounds). Attendance and appropriate participation in on-ward activities are the primary responsibility of the patient. While there is less need for staff support and direct supervision, such support and supervision, when necessary, shall be provided and shall promote the goals of the treatment plan. Staff escort is required for all off-ward activities provided on or off hospital grounds. Brief home visits are permitted at this level, if clinically indicated and if

the family is capable and willing to provide direct supervision for the duration of the visit.

(c) In addition to the risk factors associated with Level I, factors to be considered in determining the appropriateness of placing a patient at Level II of supervision include, but are not limited to:

1. No longer on special observation or precautions for dangerous behavior such as suicide, arson, or assault risk;
2. Elopement or walkaway risk;
3. Medical risk;
4. Follows general directions and generally attends on ward therapies and programs on a regular basis;
5. Psychotic symptoms or mood disturbances may be present but does not act in response to them in such a way as to create an imminent risk of harm;
6. Mildly confused and disoriented but able to adapt to unfamiliar surroundings;
7. Able to control impulses except when severely stressed; or
8. Risk of accidental injury.

(d) The patient's demonstrated ability to participate in treatment activities by virtue of a greater degree of self-initiated responsible participation shall result in involvement and assignment to more off-ward activities and programs. To

maximize the probability of success in the change in the treatment regimen, these off-ward activities shall be structured and supportive with staff escort at all times. On-ward therapies and activities, however, shall utilize the patient's developing sense of responsibility and initiative as staff provides less direct supervision and structure while continuing to evaluate progress frequently.

10:36-1.7 Level III definition, criteria and program structure

(a) Patients at Level of Supervision III are those who generally are able to control dangerous impulses and who thus require less supervision than that present at Level II.

(b) Programming and services are provided on-ward and off-ward (on or off hospital grounds) with an increasing emphasis upon off-ward programming. The frequency, duration and types of unescorted off-ward activities are determined by the treatment team. The patient's participation in each scheduled off-ward program and on hospital grounds shall be defined by time accountability and the clinical relevance of the program. Participation in unescorted off-ward activities shall be implemented incrementally. Staff-escorted community activities are permitted at this level. Brief home visits are permitted at this level if the family is capable and willing to provide the level of supervision considered necessary by the treatment team in consideration of the clinical needs of the patient.

(c) In addition to the risk factors associated with Levels I and II, factors to be considered in determining the appropriateness of placing a patient at Level III of supervision include, but are not limited to:

1. Minimal psychotic or mood disordered symptoms, or if chronic residual symptoms are still present, does not act in response to them;

2. Oriented and aware of surroundings;

3. Cooperative with established plan and schedule of activities;

4. Appropriate on and off ward behavior resulting in no precautions for a certain number of days/weeks (to be set by treatment team);

5. Minimal elopement/walkaway risk;

6. Able to control impulses except when severely stressed;

7. If recent history and behavior indicates substance abuse risk, or risk of other dangerous behavior, cooperation with search and/or other procedures that the treatment team determines necessary and documents in master treatment plan;

8. History of anti-social behavior;

9. History of sexually inappropriate behavior;

10. History of elopement or walkaway risk;

11. History of criminal behavior;

12. History of violent behavior directed toward others;

13. Ambulatory patients and non-ambulatory patients who have demonstrated an ability to utilize their adaptive equipment safely; or

14. Medical problems requiring only intermittent evaluation by ward staff.

(d) The patient's responsible and cooperative participation in activities both on-ward and off-ward but on hospital grounds, and escorted off hospital grounds activities is expected to result in the team encouraging more independent activity by gradually increasing the number of unescorted off-ward programs. These programs and activities generally include centralized (off-ward) social and rehabilitative programs and activities. Staff shall monitor Level III patients to ensure program participation.

10:36-1.8 Level IV definition, criteria and program structure

(a) Patients at Level of Supervision IV are those who pose no or minimal risk of harm to self, others or property and who may be discharged upon finalization of after-care and housing plans.

(b) Attendance and appropriate participation at any approved activity on-ward, off-ward, or off-grounds is expected through the self-initiated behavior of the patient, and is without staff escort. Determination of recommended programs and activities is the responsibility of the treatment team.

(c) In addition to the risk factors associated with Levels I, II and III, factors to be considered in determining the appropriateness of placing a patient at Level IV of supervision include, but are not limited to:

1. No recent instances of substance abuse;

2. Oriented to and capable of utilizing community or transportation services;

3. Patient exhibits sound judgment under reasonable conditions;

4. Patient exhibits accountability and responsibility through adherence to treatment plan program schedule;

5. History of alcohol and substance abuse or of treatment non-compliance;

6. Past history of violence, threats towards identifiable third parties; or

7. No physical/medical contraindications.

(d) Programming and activities at this level are the least structured. While staff shall evaluate the patient's behavior for compliance with the schedule, direct supervision shall be decreased. Most often, community-based programs and activities (for example, transitional programs, community day programs, community trips), as well as larger group activities, shall be part of the individual's overall program at Level IV.

Subchapter 2. Clinical Review Procedures for Special Status Patients.

10:36-2.1 Statement, purpose and scope

(a) The Division recognizes that the management of some patients within its hospital system requires a more comprehensive and complete evaluation of the clinical, judicial and administrative factors relevant to treatment plan development and implementation.

(b) The purpose of this procedure is to establish a mechanism which provides a comprehensive review of the clinical treatment and management of special status patients through ensuring appropriate treatment interventions, levels of supervision and planning at the time of movement to less restrictive settings, decrease of structures and security, or discharge, and to ensure that hospital staff conduct an appropriate risk/benefit assessment balancing the patient's need for effective treatment and the safety needs of all parties when special status patients are given privileges. However, nothing in these procedures is intended to alter the responsibility of hospital staff to comply with the provisions of valid court orders regarding specific patients and with the Patient Bill of Rights at N.J.S.A. 30:4-24.2.

(c) Special status patients are those who satisfy the definition of the term at N.J.A.C. 10:36-1.2.

10:36-2.2 Special Status Patient Review Committee composition

(a) The Clinical Director/Medical Director shall appoint the members comprising the Special Status Patient Review Committee ("SSPRC" or "Committee") and shall designate a Committee Chairperson.

(b) The composition of the SSPRC shall include, but need not be limited to: the Medical/Clinical Director or Chief of Psychiatry, the Director of Psychology, the Director of Nursing Services, the Director of Rehabilitation Services, and the Director of Social Services. One of these individuals shall be a psychiatrist. These individuals may appoint designees to the Committee who are of sufficient experience to appropriately review these matters. Such designees shall not endorse recommendations they may have already made as a treatment team member.

10:36-2.3 Procedures

(a) Whenever a patient objects to the treatment team's recommendation regarding the levels determination, the SSPRC Chairperson shall designate a committee member to interview the patient within the 10-day time frame for the SSPRC's decision-making established in (d) below.

(b) The treatment team shall prepare and forward to the SSPRC Chairperson/designee in as timely a manner as possible the information concerning the patient whose status requires clinical review. Whenever a

recommendation regarding a level of supervision is forwarded to the SSPRC and the special status patient has an opinion that differs from his or her treatment team, a statement by the patient and/or a summary of the patient's opinion shall be included in the information forwarded to the SSPRC.

(c) The SSPRC Chairperson may designate a committee member to interview the patient prior to the committee review whenever, in his or her judgment, the situation warrants. One of the special status patient's treatment team members familiar with the current level recommendation shall meet with the SSPRC during their review process.

(d) The SSPRC shall meet and review the team proposals within 10 working days of receipt of the information.

(e) The SSPRC Chairperson or designee shall forward the committee's recommendations in response to the team proposals to the Clinical Director within two working days.

(f) The Clinical Director/Medical Director shall review the SSPRC recommendations regarding endorsement of the team proposals and respond to the Chairperson within two working days by either endorsing the SSPRC recommendation, or withholding endorsement. The Clinical Director/Medical Director may request additional information from the treatment team; however,

such request and the team's response shall be made within the same two-day period. All recommendations must be endorsed by the Clinical Director/Medical Director prior to implementation.

(g) The Clinical Director/Medical Director shall periodically attend SSPRC meetings in his or her institution in order to monitor the thoroughness and quality of clinical recommendations and compliance with this policy and procedure. Additionally, the Quality Assurance Department within each hospital or other designee of the hospital CEO shall also monitor the hospital's compliance with the rules within this subchapter.

(h) Whenever a hospital treatment team and the hospital's SSPRC recommend the granting of a supervision decrease to Level III or Level IV or the discharging of any patient subject to the hospital's SSPRC review procedures, the documentation regarding those supervision and discharge reviews shall be forwarded to the Division Medical Director and his or her designee by the SSPRC Coordinator within two days of finalizing such recommendation to ensure that an appropriate risk/benefit assessment balancing the patient's need for effective treatment and the safety needs of all parties has been performed. Final Division Medical Director action shall be communicated to hospital staff no more than five working days after receipt of the hospital Clinical/Medical Director approval.

(i) Whenever N.J.S.A. 30:4-27.17b requires written notice to a county prosecutor or deputy attorney general who participated in a patient's commitment, a designated hospital staff member shall notify the appropriate individual in accordance with that statutory provision.

(j) The rationale supporting the levels decision shall be entered into the SSPRC's meeting minutes and the patient's records.

10:36-2.4 SSPRC Coordinator

(a) Each hospital shall designate a staff person to be responsible for coordination of all activities relative to the functioning of the SSPRC. The responsibilities of the coordinator shall include:

1. Consultation with treatment teams regarding preparation of information to be submitted to the SSPRC;
2. Maintaining files on all cases presented to the SSPRC;
3. Functioning as executive secretary to the SSPRC (that is, recording, distributing and filing of minutes); and
4. Being responsible for the coordination of information flow among treatment teams, SSPRCs, hospital administration and Central Office regarding special or extenuating circumstances, current or pending legislation, etc., relative to cases under consideration of the SSPRC.

10:36-2.5 (Reserved)

Repealed by R.1993 d.58, effective February 1, 1993.

See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

Section was "Quality assurance activities."

Subchapter 3. Transfers of Involuntarily Committed Patients between State Psychiatric Facilities.

10:36-3.1 Purpose

The purpose of this subchapter is to define the factors to be used by State psychiatric facility staff in evaluating the need for inter-hospital transfers among the facilities cited in N.J.A.C. 10:36-3.2. The subchapter also delineates the procedures related to such transfers.

10:36-3.2 Scope

(a) The rules of this subchapter apply in all instances to involuntarily committed patients who are residing at and being considered for transfer to any of the following facilities specified in N.J.S.A. 30:4-160:

1. Greystone Park Psychiatric Hospital;
2. Trenton Psychiatric Hospital;
3. Ancora Psychiatric Hospital;
4. The Ann Klein Forensic Center; and
5. The Senator Garrett W. Hagedorn Psychiatric Hospital.

(b) Prior to a patient's initial commitment hearing, only emergency transfers may be made. Regardless of a patient's transfer to another State hospital, the initial commitment hearing shall take place within 20 days of initial inpatient admission to the original facility and shall not be postponed by the request of staff at the receiving hospital, except in the event that security concerns or a patient's condition requires an adjournment.

10:36-3.3 Factors

(a) Any of the factors described below may serve as a basis for the transfer of a patient from and to any facility cited in N.J.A.C. 10:36-3.2:

1. To place him or her in closer proximity to family members;

i. If a patient and his or her family members disagree on a transfer request based on proximity to family members, a clinical determination shall be made by the hospital staff based solely on the clinical best interest of the patient;

2. To place the patient in the appropriate hospital according to the patient's residence (catchment area);

3. To provide a new clinical and personal relationship in exceptional circumstances when a treatment impasse has developed over a sustained period of time;

4. To provide greater or less clinical structure or security;

5. To participate in a specialized medical or psychiatric service that is offered at another hospital or in the community that is more

accessible from the receiving hospital;

6. As a result of a change in legal status;

7. To spare patients the consequences of overcrowding at a specific mental health facility;

8. In response to natural catastrophes, fires, or other life-safety concerns which necessitate transfer; or

9. As a consequence of inter-regional consolidation of services.

(b) A patient's stated preference for treatment at a particular State psychiatric facility shall always be a relevant consideration in transfer decisions. Transfers over the objection of a patient are permitted, however, when a clinical determination has concluded that the transfer is in the transferee's clinical best interest or necessary for the safety of other patients or administratively necessary due to a factor listed in (a) above. A transfer is permitted only when, in the judgment of the treatment team, the transfer's permissible purpose outweighs any potential harm to the patient from the transfer.

1. When a transferring facility is capable of meeting the clinical or administrative purpose for a proposed transfer as contained in the factors at (a) above, an objecting patient shall not be transferred.

2. Transfers shall be to the least restrictive available treatment alternative available to achieve the purposes of the transfer request as contained in the factors at (a) above.

10:36-3.4 General procedures

(a) This section delineates the conditions and procedures applicable to all transfers to and from State psychiatric hospitals.

(b) Each CEO shall designate a staff member to function as a transfer coordinator who, for purposes of transfer arrangement, shall report directly to the CEO.

(c) A written request for transfer, supported by a statement of the factors justifying the request, shall be forwarded from the transfer coordinator of the sending hospital to the transfer coordinator of the receiving hospital. All requests for transfers shall be supported by clinical considerations.

(d) Transfers occurring as a result of overcrowding, life-safety concerns, natural catastrophes, or consolidation of services shall require the approval of the Director, Division of Mental Health Services.

(e) The following procedures shall be followed in cases of non-emergent transfers:

1. The transfer coordinator of the sending hospital shall consult with the transfer coordinator of the receiving hospital. If they agree to the transfer, they shall arrange for a specific date and time for the transfer to occur.

2. Hospital staff shall actively promote resident input into non-emergency transfer decisions.

3. At least seven days prior to the transfer date, staff at the sending institution shall notify the relevant County Adjusters, family and attorney of the patient being transferred of the transfer decision, the reason for the transfer and the procedural rights in this chapter.

4. It is the responsibility of the hospital initiating the transaction to make arrangements for transporting the patient from one facility to the other.

5. If the transfer coordinators do not agree on the transfer, the matter shall be referred to the CEOs of the respective institution for resolution.

6. If the CEOs do not agree, the case shall be referred for resolution to the appropriate regional Assistant Directors, Division of Mental Health Services, who may, in making their decision, request clinical and technical input from hospital central office staff. Resolution, in instances of continuing disagreement, rests with the Division Director or the Director's designee.

7. All transfer requests are to be handled in a timely manner.

8. The basis for the transfer decision shall be documented in the patient's record.

(f) The following procedures shall be followed in cases of emergency

transfers:

1. Emergency shall be defined, for the purposes of this subchapter, as imminent danger of serious bodily harm to self or others, as evidenced by a recent incident or a change in psychiatric status which less restrictive available treatment alternatives other than transfer cannot adequately address and which requires removal from the patient's current setting. Only the factors in N.J.A.C. 10:36-3.3(a)4 or 8 may serve as the basis for an emergency transfer.

2. Emergency transfers shall take place only upon prior agreement between the CEOs of the institutions.

3. Staff at the sending hospital shall notify the relevant County Adjuster(s), family, and attorney of the resident being transferred of the transfer and the reason for the transfer as soon as possible after the transfer decision has been made.

4. The transfer coordinator or, when unavailable, the administratively responsible person of the sending hospital must contact directly the CEO or transfer coordinator at the receiving institution and transmit verbally the factors supporting the transfer, as well as the reasons for the emergent nature of the transfer. Supporting documentation must be faxed prior to the final decision to transfer.

5. If, after transfer, the CEO of the receiving hospital objects to an emergency transfer, he or she shall review the case with the CEO of the sending institution. If agreement cannot be reached, the matter

shall be referred to the Assistant Director of the receiving region.

6. That Assistant Director shall consult with his or her counterpart from the sending region to resolve the issue.

7. If agreement cannot be reached by the Assistant Directors, the issue shall be referred for resolution to the Director or the Director's designee.

8. The basis for the transfer decision shall be documented in the patient's record.

10:36-3.5 Procedures when patients object to transfer

(a) Regarding non-emergency transfers, the following apply:

1. If a patient objects to such a transfer, he or she shall be provided an opportunity to state the basis for his or her objection, and present any relevant facts including statements by other individuals, with or through a representative if so desired, before an individual who is not a member of the treatment team seeking transfer. The hospital's Clinical Director/ Medical Director shall designate this individual, who may be a member of the office of the hospital's clinical director or other hospital staff member capable of providing an independent review of the need for the proposed transfer.

2. The individual who reviews the proposed transfer shall have the authority to approve or disapprove the proposed transfer.

3. Patients and their representatives may submit in writing their views

regarding a non-emergency transfer prior to its implementation. Upon request by or consent of the patient, the patient and his or her representatives may request an opportunity to discuss the proposed, non-emergency transfer with a Division representative prior to implementation of the transfer.

(b) Regarding emergency transfers, the following apply:

1. In an emergency as defined at N.J.A.C. 10:36-3.4(e)1, a patient may be transferred in accordance with procedures outlined at N.J.A.C. 10:36- 3.4(e).

2. If a patient or a representative of the patient objects to such a transfer, they may submit their position in writing to the Division after implementation of the transfer. A designee of the Division Director shall review the basis for the transfer after the transfer, and shall provide the patient or his or her representative with an opportunity to state the basis for their objection and present any relevant facts or statements. The designee shall not be a member of the patient's treatment team at either the sending or receiving hospital and shall provide an independent review of the need for the proposed transfer. The designee shall have the authority to approve or disapprove the proposed transfer. This decision shall be in writing and shall become part of the patient's clinical record.